## Senate Study Bill 1161 - Introduced

SEN	ATE FILE
ВУ	(PROPOSED COMMITTEE ON
	HUMAN RESOURCES BILL BY
	CHAIRPERSON SEGEBART)

## A BILL FOR

- 1 An Act relating to prior authorization by a utilization review
- 2 entity for coverage of health care services and including
- 3 applicability provisions.
- 4 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

- 1 Section 1. NEW SECTION. 514F.7 Prior authorization.
- 2 l. Definitions. For purposes of this section:
- 3 a. (1) "Adverse determination" means a determination by
- 4 a utilization review entity that an admission, availability
- 5 of care, continued stay, or other health care service, other
- 6 than a dental care service, that is a covered benefit has been
- 7 reviewed and, based upon the information provided, does not
- 8 meet the utilization review entity's requirements for medical
- 9 necessity, appropriateness, health care setting, level of care,
- 10 or effectiveness, and the requested service or payment for the
- 11 service is therefore denied, reduced, or terminated.
- 12 (2) For the purposes of denial of a dental care service,
- 13 "adverse determination" means a determination by a utilization
- 14 review entity that a dental care service that is a covered
- 15 benefit has been reviewed and, based upon the information
- 16 provided, does not meet the utilization review entity's
- 17 requirements for medical necessity, and the requested service
- 18 or payment for the service is therefore denied, reduced, or
- 19 terminated in whole or in part.
- 20 (3) "Adverse determination" does not include a denial of
- 21 coverage for a service or treatment specifically listed in plan
- 22 or evidence of coverage documents as excluded from coverage.
- 23 b. "Authorization" means a determination by a utilization
- 24 review entity that a requested health care service has been
- 25 reviewed and, based upon the information provided, meets the
- 26 utilization review entity's requirements for medical necessity,
- 27 appropriateness, health care setting, level of care, or
- 28 effectiveness, and that payment will be made for the requested
- 29 service.
- 30 c. "Clinical review criteria" means the written policies,
- 31 screening procedures, drug formularies or lists of covered
- 32 drugs, determination rules, determination abstracts, clinical
- 33 protocols, practice guidelines, medical protocols, and any
- 34 other criteria or rationale used by a utilization review entity
- 35 to determine the necessity and appropriateness of health care

1 services.

- 2 d. "Covered person" means a policyholder, subscriber,
- 3 enrollee, or other individual participating in a health benefit
- 4 plan. "Covered person" includes a covered person's legally
- 5 authorized representative.
- 6 e. "Dental care services" means diagnostic, preventive,
- 7 maintenance, and therapeutic dental care that is provided in
- 8 accordance with chapter 153.
- 9 f. "Emergency health care services" means health care items
- 10 and services furnished or required to evaluate and treat an
- 11 emergency medical condition.
- 12 g. "Emergency medical condition" means the sudden and, at
- 13 the time, unexpected onset of a health condition or illness
- 14 that manifests itself by symptoms of sufficient severity,
- 15 including but not limited to severe pain, that an ordinarily
- 16 prudent person, possessing an average knowledge of health and
- 17 medicine, could reasonably expect the absence of immediate
- 18 medical attention to result in a serious impairment to bodily
- 19 functions, serious dysfunction of a bodily organ or part, or
- 20 would place the person's health in serious jeopardy.
- 21 h. "Facility" means an institution providing health care
- 22 services or a health care setting, including but not limited
- 23 to hospitals and other licensed inpatient centers, ambulatory
- 24 surgical or treatment centers, skilled nursing centers,
- 25 residential treatment centers, diagnostic, laboratory and
- 26 imaging centers, and rehabilitation and other therapeutic
- 27 health settings.
- 28 i. "Health benefit plan" means a policy, contract,
- 29 certificate, or agreement offered or issued by a health carrier
- 30 to provide, deliver, arrange for, pay for, or reimburse any of
- 31 the costs of health care services.
- 32 j. "Health care professional" means a physician or other
- 33 health care practitioner licensed, accredited, registered, or
- 34 certified to perform specified health care services consistent
- 35 with state law.

- 1 k. "Health care provider" or "provider" means a health care
  2 professional or a facility.
- 3 1. "Health care services" means services for the diagnosis,
- 4 prevention, treatment, cure, or relief of a health condition,
- 5 illness, injury, or disease provided by a health care provider.
- 6 "Health care services" includes dental care services and the
- 7 provision of pharmaceutical products or services or durable
- 8 medical equipment.
- 9 m. "Health carrier" means an entity subject to the
- 10 insurance laws and regulations of this state, or subject
- ll to the jurisdiction of the commissioner, including an
- 12 insurance company offering sickness and accident plans, a
- 13 health maintenance organization, a nonprofit health service
- 14 corporation, a plan established pursuant to chapter 509A
- 15 for public employees, or any other entity providing a plan
- 16 of health insurance, health care benefits, or health care
- 17 services. "Health carrier" includes, for purposes of this
- 18 section, an organized delivery system.
- 19 n. "Medically necessary health care services" means
- 20 health care services and supplies that a prudent health care
- 21 provider would provide to a covered person for the purpose
- 22 of preventing, diagnosing, or treating a health condition,
- 23 illness, injury, or disease, or the symptoms of an illness,
- 24 injury, or disease in a manner that is all of the following:
- 25 (1) In accordance with generally accepted standards of
- 26 medical practice.
- 27 (2) Clinically appropriate in terms of type, frequency,
- 28 extent, site, and duration.
- 29 (3) Not primarily for the economic benefit of the health
- 30 benefit plan or health care provider or for the convenience of
- 31 the covered person or the health care provider.
- 32 o. "Organized delivery system" means an entity system
- 33 authorized under 1993 Iowa Acts, ch. 158, and licensed by the
- 34 director of public health, and performing utilization review.
- 35 p. "Prior authorization" means the process by which a

- 1 utilization review entity determines the medical necessity
- 2 or medical appropriateness of otherwise covered health care
- 3 services prior to the rendering of such health care services
- 4 including but not limited to preadmission review, pretreatment
- 5 review, utilization, and case management. "Prior authorization"
- 6 includes a utilization review entity's requirement that a
- 7 covered person or health care provider notify the utilization
- 8 review entity prior to receiving or providing a health care
- 9 service.
- 10 q. "Urgent health care service" means a health care service
- 11 subject to prior authorization prescribed for a covered
- 12 person, for which the time periods for making a nonexpedited
- 13 prior authorization, could, in the opinion of a health care
- 14 professional with knowledge of the covered person's medical
- 15 condition, do either of the following:
- 16 (1) Seriously jeopardize the life or health of the covered
- 17 person or the ability of the covered person to regain maximum
- 18 function.
- 19 (2) Subject the covered person to severe pain that cannot be
- 20 adequately managed without the health care service that is the
- 21 subject of prior authorization.
- 22 r. (1) "Utilization review entity" means an individual or
- 23 entity that performs prior authorization for one or more of the
- 24 following entities:
- 25 (a) An employer with employees in Iowa who are covered under
- 26 a health benefit plan.
- 27 (b) A health carrier.
- 28 (c) Any individual or entity that provides, offers to
- 29 provide, or administers hospital, outpatient, medical, or other
- 30 health care services.
- 31 (2) "Utilization review entity" includes a health carrier
- 32 that performs prior authorization for its own health benefit
- 33 plans.
- 34 2. Prior authorization requirements and restrictions —
- 35 disclosure.

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- 1 a. A utilization review entity shall make any current prior 2 authorization requirements or restrictions, including clinical 3 review criteria, readily accessible on the entity's internet 4 site to covered persons, health care providers, and the general
- 5 public. The restrictions and requirements shall be described
- 6 in detail but in easily understandable language.
- 7 b. A utilization review entity shall not implement a new or
- 8 amended prior authorization requirement or restriction until
- 9 the utilization review entity has done both of the following:
- 10 (1) Updated the utilization review entity's internet site
- 11 to reflect the new or amended requirement or restriction.
- 12 (2) Provided written notice of the new or amended
- 13 requirement or restriction not less than sixty calendar
- 14 days before the new or amended requirement or restriction is
- 15 implemented to health care providers contracted to provide
- 16 health care services pursuant to a health benefit plan to which
- 17 the prior authorization requirement or restriction applies.
- 18 c. A utilization review entity shall make statistics
- 19 available on the entity's internet site in a readily accessible
- 20 format that indicate how prior authorization is applied on the
- 21 basis of each of the following:
- 22 (1) Specialty of the health professional.
- 23 (2) Type of health care service requested.
- 24 (3) The clinical indication offered for requesting a health 25 care service.
- 26 (4) Reason for denial of prior authorization.
- 27 3. Utilization review entity's obligations with respect to 28 prior authorization.
- 29 a. If a utilization review entity requires prior
- 30 authorization for coverage of a nonurgent health care service,
- 31 the entity shall either give prior authorization covering the
- 32 nonurgent health care service or make an adverse determination
- 33 denying coverage of the nonurgent health care service within
- 34 five calendar days of obtaining all necessary information
- 35 to give authorization or make an adverse determination. A

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- 1 contractual timeline may vary from this standard but in no
- 2 event shall the timeline for giving authorization or making an
- 3 adverse determination for coverage of a nonurgent health care
- 4 service exceed five calendar days.
- 5 b. If a utilization review entity requires prior
- 6 authorization for coverage of an urgent health care service,
- 7 the entity shall either give prior authorization covering the
- 8 urgent health care service or make an adverse determination
- 9 denying coverage of the urgent health care service and notify
- 10 the covered person and the covered person's health care
- 11 provider of that authorization or denial within seventy-two
- 12 hours of obtaining all necessary information to give
- 13 authorization or make an adverse determination. A contractual
- 14 timeline may vary from this standard but in no event shall
- 15 the timeline for giving authorization or making an adverse
- 16 determination for coverage of an urgent health care service
- 17 exceed seventy-two hours.
- 18 c. For purposes of this subsection, "necessary information"
- 19 includes the results of a face-to-face clinical evaluation or
- 20 second opinion that may be required.
- 21 4. Utilization review entity's obligations with respect to
- 22 coverage of emergency health care services.
- 23 a. A utilization review entity shall not require prior
- 24 authorization for emergency transportation to a hospital or for
- 25 the provision of emergency health care services.
- 26 b. A utilization review entity shall allow a covered person
- 27 and the covered person's health care provider a minimum of
- 28 twenty-four hours following an emergency hospital admission
- 29 or the provision of emergency health care services to the
- 30 covered person, to notify the utilization review entity of
- 31 the emergency hospital admission or provision of emergency
- 32 health care services. If the emergency hospital admission or
- 33 provision of emergency health care services occurs on a holiday
- 34 or weekend, the utilization review entity shall not require
- 35 such notification until the next business day after the holiday

1 or weekend.

- 2 c. A utilization review entity shall authorize coverage
- 3 of emergency health care services necessary to screen and
- 4 stabilize a covered person. If a health care provider
- 5 certifies in writing to a utilization review entity within
- 6 seventy-two hours of a covered person's admission to a hospital
- 7 that the covered person's condition required emergency
- 8 health care services, that certification shall create a
- 9 presumption that the emergency health care services were
- 10 medically necessary and such presumption may be rebutted only
- 11 if the utilization review entity can establish, by clear and
- 12 convincing evidence, that the emergency health care services
- 13 provided were not medically necessary.
- 14 d. A determination of the medical necessity or
- 15 appropriateness of emergency health care services provided to
- 16 a covered person shall not be based on whether or not those
- 17 services were provided by a health care provider under contract
- 18 to provide health care services pursuant to a health benefit
- 19 plan. Requirements or restrictions on coverage of emergency
- 20 health care services provided by health care providers not
- 21 under contract to provide services pursuant to a health benefit
- 22 plan shall not be greater than requirements or restrictions
- 23 that apply when those services are provided by a health care
- 24 provider under contract to provide such services pursuant to
- 25 the health benefit plan.
- 26 e. If a covered person receives emergency health
- 27 care services that require immediate postevaluation or
- 28 poststabilization health care services, a utilization review
- 29 entity shall give prior authorization or make an adverse
- 30 determination within sixty minutes of receiving a request for
- 31 prior authorization. If the utilization review entity does not
- 32 give authorization for or deny coverage of the postevaluation
- 33 or poststabilization health care services within sixty minutes
- 34 of receiving the request, coverage of such services shall be
- 35 deemed to be authorized.

- 1 5. Retrospective denial. A utilization review entity shall
- 2 not revoke, limit, condition, or restrict prior authorization
- 3 after the date on which a health care provider provides the
- 4 health care services for which authorization was received. Any
- 5 language that attempts to disclaim payment for health care
- 6 services that have received prior authorization shall be null
- 7 and void.
- 8 6. Duration. A prior authorization shall be valid for
- 9 not less than one year from the date a health care provider
- 10 receives the prior authorization.
- 11 7. Expedited renewal. A utilization review entity shall
- 12 develop an expedited process for the renewal of an existing
- 13 prior authorization including a certification that the factors
- 14 constituting medical necessity or medical appropriateness
- 15 of the health care services for which renewal of prior
- 16 authorization is sought remain unchanged from the factors
- 17 that were considered before issuance of the original prior
- 18 authorization.
- 19 8. Administrative services fees.
- 20 a. A utilization review entity shall establish an
- 21 administrative services fee schedule for prior authorization
- 22 determinations, consistent with the federal Medicare
- 23 resource-based relative value scale methodology used to
- 24 reimburse health care professionals for medical reports. The
- 25 fee schedule shall be utilized by the utilization review
- 26 entity to determine the amount of payments to health care
- 27 professionals who complete administrative services required by
- 28 the utilization review entity as a condition of giving prior
- 29 authorization or making an adverse determination.
- 30 b. For the purpose of this subsection, "administrative
- 31 services" includes but is not limited to peer-to-peer
- 32 clinical consultations or second opinions, and completion of
- 33 certification documentation. "Administrative services" does not
- 34 include those services rendered by a health care professional
- 35 in the provision of health care services to a covered person.

- 9. Failure to comply with this section. Upon the failure
- 2 of a utilization review entity to comply with deadlines or
- 3 other requirements specified in this section, any health care
- 4 services subject to prior authorization shall be deemed to be
- 5 automatically preauthorized.
- 6 10. Severability. If any provision of this section or the
- 7 application of this section to any person or circumstance is
- 8 held invalid, such invalidity shall not affect other provisions
- 9 or applications of the section which can be given effect
- 10 without the invalid provision or application.
- 11 Sec. 2. APPLICABILITY. This Act applies to a health benefit
- 12 plan that is delivered, issued for delivery, continued, or
- 13 renewed in this state on or after January 1, 2018.
- 14 EXPLANATION
- The inclusion of this explanation does not constitute agreement with
- the explanation's substance by the members of the general assembly.
- 17 This bill relates to prior authorization of health
- 18 care services by a utilization review entity and includes
- 19 applicability provisions.
- 20 The bill provides that a utilization review entity that
- 21 requires prior authorization for coverage of health care
- 22 services must make its prior authorization requirements or
- 23 restrictions readily accessible on its internet site. The
- 24 entity cannot implement new or amended prior authorization
- 25 requirements or restrictions until its internet site has been
- 26 updated and health care providers contracted to provide the
- 27 health care services to which the requirements or restrictions
- 28 apply have been given not less than 60 calendar days' written
- 29 notice of the changes. A utilization review entity must make
- 30 specified statistics about application of prior authorization
- 31 available on its internet site.
- 32 If prior authorization is required for coverage of a
- 33 nonurgent health care service, a utilization review entity
- 34 must either give prior authorization to cover the service or
- 35 make an adverse determination denying such coverage within

- 1 five calendar days of obtaining all necessary information.
- 2 If prior authorization is required for coverage of an urgent
- 3 health care service, a utilization review entity must give
- 4 prior authorization to cover the service or make an adverse
- 5 determination denying such coverage within 72 hours of
- 6 obtaining all necessary information. For purposes of the bill,
- 7 "necessary information" includes the results of a face-to-face
- 8 clinical evaluation or second opinion that may be required.
- 9 A utilization review entity cannot require prior
- 10 authorization for emergency transportation to a hospital or for
- 11 the provision of emergency health care services. A utilization
- 12 review entity must allow a person covered by a health benefit
- 13 plan and the person's health care provider a minimum of 24
- 14 hours to notify the entity following an emergency hospital
- 15 admission or the provision of emergency health care services,
- 16 on the next business day if the admission or provision of
- 17 services occurs on a holiday or weekend.
- 18 A utilization review entity shall authorize coverage
- 19 of emergency health care services necessary to screen and
- 20 stabilize a covered person. If a health care provider
- 21 certifies in writing to a utilization review entity within
- 22 72 hours of a covered person's admission to a hospital that
- 23 the covered person's condition required emergency health care
- 24 services, that certification shall create a presumption that
- 25 the emergency health care services were medically necessary and
- 26 such presumption may be rebutted only if the utilization review
- 27 entity can establish, by clear and convincing evidence, that
- 28 the emergency health care services provided were not medically
- 29 necessary.
- 30 A determination of the medical necessity or appropriateness
- 31 of emergency health care services provided to a covered person
- 32 cannot be based on whether or not those services were provided
- 33 by a health care provider under contract to provide health care
- 34 services pursuant to a health benefit plan. Requirements or
- 35 restrictions on coverage of emergency health care services

- 1 provided by health care providers not under contract to
- 2 provide services pursuant to a health benefit plan cannot be
- 3 greater than restrictions or requirements that apply when those
- 4 services are provided by a health care provider under contract
- 5 to provide such services pursuant to the health benefit plan.
- 6 If a covered person receives emergency health care services
- 7 that require immediate postevaluation or poststabilization
- 8 health care services, a utilization review entity shall give
- 9 authorization or make an adverse determination within 60
- 10 minutes of receiving a request for prior authorization, and if
- 11 the entity does not authorize or deny coverage of the health
- 12 care services within that time, coverage of such services is
- 13 deemed to be authorized.
- 14 A utilization review entity cannot revoke, limit, condition,
- 15 or restrict a prior authorization after the date on which a
- 16 health care provider provides the health care services for
- 17 which authorization was received. Any language that attempts
- 18 to disclaim payment for health care services that have received
- 19 prior authorization is null and void.
- 20 A prior authorization is valid for not less than one year
- 21 from the date a health care provider receives the prior
- 22 authorization. A utilization review entity shall develop
- 23 an expedited process for the renewal of an existing prior
- 24 authorization including a certification that the factors
- 25 constituting medical necessity or medical appropriateness of
- 26 the health care services for which the renewal is sought remain
- 27 unchanged from the factors that were considered before issuance
- 28 of the original prior authorization.
- 29 A utilization review entity is required to establish an
- 30 administrative services fee schedule for prior authorization
- 31 determinations, consistent with the federal Medicare
- 32 resource-based relative value scale methodology used to
- 33 reimburse health care professionals for medical reports. The
- 34 fee schedule shall be utilized by the utilization review
- 35 entity to determine the amount of payments to health care

- 1 professionals who complete administrative services required
- 2 by the utilization review entity as a condition of making
- 3 a prior authorization determination. "Administrative
- 4 services" includes but is not limited to peer-to-peer
- 5 clinical consultations or second opinions, and completion
- 6 of certification documentation. "Administrative services"
- 7 does not include those services rendered by a health care
- 8 professional in the provision of health care services to a
- 9 covered person.
- 10 If a utilization review entity fails to comply with
- 11 deadlines or other requirements of the bill, any health care
- 12 services subject to prior authorization are deemed to be
- 13 automatically preauthorized.
- 14 The provisions of the bill are severable and if any provision
- 15 or application of a provision is held invalid, the other
- 16 provisions or applications can be given effect without the
- 17 invalid provision or application.
- 18 The provisions of the bill are applicable to a health benefit
- 19 plan that is delivered, issued for delivery, continued, or
- 20 renewed in this state on or after January 1, 2018.